Choice Plus

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Blue Cross® Blue Shield® of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Coverage Period: 01/01/2013-12/31/2013
Coverage for: Individual | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mesaaz.gov/benefits** or by calling 1-866-288-5788.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$200/**member Out-of-network: **$1,000/**member	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the allowed amount that you will pay for most services is 10% in-network and 30% out of network. Copays, access fees, balance bills, charges for non-covered services and precertification charges don't count toward deductible.
Are there other deductibles for specific services?	Yes, $50 for up to 30-day supply Brand prescription drug expenses obtained at retail	You don't have to meet **deductibles** for other specific services except prescription drugs, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$1,000/**member Out-of-network: None	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have funds in an HRA or FSA, you may be able to use those funds to cover your out-of-pocket expense.
What is not included in The out–of–pocket limit?	Premiums, deductibles, copays, access fees, precertification charges, balance-bills, costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. You must keep paying them even if you reach your out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	Yes, $2,000,000	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.azblue.com or call 1-866-288-5788 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers.

Questions: Call 1-866-288-5788 or visit us at www.azblue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-866-288-5788 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your benefit book for more information about **excluded services**.

- **Copays** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you lower cost-share amounts when you use **in-network providers**, who usually accept the plan's allowed amount. Most out-of-network providers may bill you for full billed charges. When you see a non-contracted, out-of-network provider, the plan will reimburse you for covered claims based on the plan allowed amount, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance & balance bill	Maximum of 25 chiropractic visits per member/calendar year. After 25 visits, precertification required or services will not be covered. Alternative Health Care Services (Acupuncturists, Naturopaths, Homeopaths) are covered at same level in- or out-of network. Some services require precertification and won't be covered without it.
	Specialist visit	10% coinsurance		
	Other practitioner office visit	10% coinsurance		
	Preventive care/screening/immunization	No charge	Not covered	Provider's diagnosis and procedure codes determine whether service is preventive.

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance & balance bill	Some imaging services require precertification and won't be covered without it.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at City of Mesa Benefits Administration: (480) 644-2299 http://www.mesaaz.gov/benefits or CVS Caremark www.caremark.com or (855) 264-5048	Generic	20% coinsurance $5 min/$50 max, 30 days or $12.50 min/ $100 max, 90 days	In-network coinsurance plus balance bill	Some drugs require precertification or step therapy review and won't be covered without it. 90-day supply obtained at mail or CVS retail only. Pay penalty price if Brand drug used when Generic is available. Cost share waived for some preventive Generic contraceptive drugs/devices. $500 maximum/person/year applies to some drugs. Mail order is not covered out of network.
	Formulary Brand	25% coinsurance $30 min/$100 max, 30 days or $75 min/ $200 max, 90 days		
	Non-Formulary Brand	40% coinsurance $50 min/$150 max, 30 days or $125 min/ $300 max, 90 days		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification Bariatric surgery not covered out-of-network.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	10% coinsurance after in-network deductible		None.
	Emergency medical transportation			Non-emergency transport requires precertification and won't be covered without it.
	Urgent care	10% coinsurance	30% coinsurance & balance bill	None.

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification Bariatric surgery not covered out-of-network.
	Physician/surgeon fee			
	Long-term acute care	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification Limited to 60 days/calendar year, combined with Skilled Nursing.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance & balance bill	Electric Convulsive Therapy (ECT) and BRCA services require precertification and won't be covered without it.
	Mental/Behavioral health inpatient services	10% coinsurance		Not covered without precertification.
	Substance use disorder outpatient services	10% coinsurance		Electric Convulsive Therapy (ECT) and BRCA services require precertification and won't be covered without it.
	Substance use disorder inpatient services	10% coinsurance		Not covered without precertification.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance & balance bill	OB-related admissions, excluding delivery, require precertification and won't be covered without it .
	Delivery and all inpatient services			

Common Medical Event	Services You May Need	Your Cost If You Use a In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	30% coinsurance & balance bill	Limited to 60 days/calendar year. Not covered without precertification. Custodial care not covered.
	Rehabilitation services EAR = Extended Active Rehabilitation Facility PT/OT/ST = Physical therapy, occupational therapy, speech therapy	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification. Plan doesn't cover group physical and occupational therapy.
	Habilitation services	Not covered	Not covered	Excluded
	Skilled nursing care In skilled nursing facility (SNF)	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification. Limited to 60 days/calendar year, combined with Long-Term Acute Care (LTAC).
	Durable medical equipment (DME)	10% coinsurance	30% coinsurance & balance bill	Precertification required for DME and prosthetics with a cost of $1,000 or greater and not covered without it. Foot orthotics limited to $500/calendar year. No coverage for foot orthotics out-of-network. Hearing aids limited to $500/calendar year, deductible & coinsurance waived. No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary.
	Hospice service	10% coinsurance	30% coinsurance & balance bill	Not covered without precertification.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Screening for members under age 5 covered under "Preventive care / screening / immunization.
	Glasses	Not covered	Not covered	Excluded.
	Dental check-up	Not covered	Not covered	Excluded.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your benefit book for other excluded services.)

- Autism spectrum disorders (ASD) – services related to treatment of
- Bariatric Surgery, out of network
- Care that is not medically necessary
- Chiropractic services after 25 visits, unless precertified
- Cosmetic surgery
- Dental care except as stated in benefit plan
- Experimental and investigational treatments
- Eye wear except after cataract surgery
- Foot orthotics in excess of $500 limit and foot orthotics obtained out of network
- Habilitation care
- Hearing aids in excess of $500 limit
- Home health /home infusion in excess of 60 day limit
- Infertility and Fertility Treatment, including reproductive and genetic services
- Long-term care (except for 60 days of Long-Term Acute Care, combined with Skilled nursing)
- Out-of-network mail order prescriptions
- Out-of-network preventive care
- Routine eye care, except members under age 5
- Routine foot care
- Services for the surgical treatment of sexual dysfunction
- Skilled nursing care in excess of 60 day limit (combined with Long-Term Acute Care)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.)

- Non-emergency care when travelling outside the U.S. (covered as out-of-network benefits)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-480-644-2299**. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-866-288-5788**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 602-864-4884.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-864-4884.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,470
- **Patient pays** $1,070

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$720
Limits or exclusions	$150
Total	$1,070

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,330
- **Patient pays** $1,070

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$790
Limits or exclusions	$80
Total	$1,070

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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